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(p) Acquired Immune Deficiency Syndrome (AIDS). (1) For rate year 1988 and thereafter, payment rates shall be adjusted, pursuant to this subdivision to provide additional payments to facilities for patients residing in [designated AIDS beds and/or] a residential health care facility designated as an AIDS facility or having a discrete AIDS unit[s] approved by the commissioner pursuant to Part 710 of this Title, or a facility which has received approval by the commissioner pursuant to Part 710 of this Title to provide services to a patient whose [primary] medical [problem] condition is [Acquired Immune Deficiency Syndrome (AIDS) as defined in section 416.12, section 421.14 and section 422.1 of of this Title,] HIV Infection Symptomatic. Such patients shall hereinafter bereferred to as [an] AIDS patients.

(2) Separate and distinct payment rates shall be calculated pursuant to this paragraph for AIDS facilities or discrete AIDS units approved by the commissioner pursuant to Part 710 of this Title. [For residential health care facilities (RHCF), adjustments to payment rates shall be made as follows:]

(i) [In determining the] The facility specific direct adjusted price per day shall be determined pursuant to paragraphs (3) and (4) of subdivision (c) of this section and further adjusted as follows [for an AIDS patient, the statewide mean, base and ceiling prices shall be calculated and applied by multiplying the case mix proxy for such patients established by this paragraph times the statewide mean, base and ceiling direct case mix neutral cost per day respectively. The case mix proxy for an AIDS patient shall be determined as follows:

(a) An AIDS patient shall be assigned a case mix proxy based on the sum of the responses to section III - Activities of Daily Living (ADLs), questions 19, 21 and 22 of the patient review instrument (PRI) as contained in section 86-2.30(i) of this Subpart as follows:

ADL TOTAL	CASE MIX PROXY

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3-6	2.67
7-8	2.84
9	3.23]

(a) In determining the direct componenet of a facility's rate pursuant to paragraphs (3) and (4) of subdivision (c) of this section for providing care for an AIDS patient in a residential health care facility designated as an AIDS facility or having a discrete AIDS unit, the case mix index for the AIDS patient shall be increased by an increment which shall be determined on the basis of the difference between allowable actual direct staffing levels and cost expenditures for the care of AIDS patients in specific patient classification groups and those of non-AIDS patients which are classified in the same patient classification groups based on data submitted by the facility. The increment to be included in a facility's rate shall be approved by the commissioner, but in no event shall the increment exceed 1.0. The facility's direct ceiling price shall be further increased by an occupancy factor of 1.089.

(b) For purposes of this [sub]paragraph, the allowable costs for the central service supply functional cost center as listed in paragraph (1) of subdivision (c) of this section shall be considered a non-comparable cost. [for an AIDS patient residing only in a discrete AIDS unit. These costs shall be initially determined based upon budget until the discrete unit operates six months at 80 percent occupancy at which time allowable costs shall be prospectively adjusted to actual costs.]

(ii) Except as identified in subparagraph (iii) of this paragraph, in [In] determining the indirect component of a facility's rate pursuant to paragraphs (4), (5), and (6) of subdivision (d) of this section for providing care for an AIDS patient in [an approved discrete AIDS unit] a residential health care facility designated as an AIDS facility or having a discrete AIDS unit, the peer group ceiling indirect [component of the rate] price shall be increased by [an AIDS] a factor of 1.20. [The AIDS factor for a specific facility shall be determined pursuant to the following formula:]

$$\left[1+\left(\frac{\text{Number of approved discrete AIDS unit beds}}{\text{Total number of approved RHCF beds}} * 20\%\right)\right]$$

(iii) In determining the indirect component of a facility's rate pursuant to paragraphs (4) and (5) of subdivision (d) of this section for a facility with a total bed complement of less than 40 beds all of which are approved by the commissioner pursuant to Part 710 of this Title solely for the care and management of AIDS patients, the peer group ceiling indirect price shall be increased by a factor of 2.00 for those facilities that are less than or equal to 16 beds and such factor shall be decreased by 0.033 for every additional bed thereafter.

[(3)]

(i) In determining the facility specific direct adjusted payment price per day pursuant to paragraph (4) of subdivision (c) of this section for an AIDS patient, the statewide mean, base and ceiling prices shall be calculated and applied by multiplying the case mix proxy for such patients established by this paragraph times the statewide mean, base and ceiling direct case mix neutral cost per day respectively.

(a) The case mix proxy for an AIDS patient shall be defined as a case mix index of 1.90.

(b) For purposes of this subparagraph, the allowable costs for the central service supply functional cost center as listed in paragraph (1) of subdivision (c) of this section shall be considered a non-comparable cost for an AIDS patient residing only in a discrete AIDS unit. These costs shall be initially determined based upon budget until the discrete unit operates six months at 80 percent occupancy at which time allowable costs shall be prospectively adjusted to actual costs.

(ii) In determining the indirect component of a facility's rate pursuant to paragraph (5) of subdivision (d) of this section for providing care for an AIDS patient in an approved discrete AIDS unit, the indirect component of the rate shall be increased by an AIDS factor. The AIDS factor for a specific facility shall be determined pursuant to the following formula:

$$1+\left(\frac{\text{Number of approved discrete AIDS unit beds}}{\text{Total number of approved HRF beds}} * 20\%\right)$$

(4) For Health Related Facilities (HRF) with less than 40 certified beds approved by the commissioner pursuant to Part 710 of this Title solely for the care and management of patients with AIDS, payment rates for an AIDS patient shall be comprised of a direct, indirect, non-comparable and capital component determined as follows:

(i) The direct component of a facility's rate determined pursuant to subdivision (c) of this section shall be the facility specific direct payment price per day after applying the RDIPAF as defined in paragraph (5) of subdivision (c) of this section. The facility specific direct payment price per day shall be calculated by multiplying the statewide mean direct case mix neutral cost per day determined pursuant to clause (a) of subparagraph (iii) of paragraph (3) of subdivision (c) of this section by the sum of the case mix index for each patient classification group as contained in appendix 13a herein plus an AIDS direct increment times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results for each patient classification group by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

(a) For purposes of this subparagraph, the AIDS direct increment shall be .60 for those facilities that are less than or equal to 16 beds and shall be decreased by .015 for every additional bed thereafter.

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(3) [A cost report shall be filed in accordance with section 86-2.2 of this Subpart for the first six month period during which a new facility which has been certified for the purpose of providing services solely to AIDS patients has received an overall average utilization of at least 80 percent of bed capacity. This report shall be properly certified within 60 days

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following the end of the six month period covered by the report. Failure to comply with this subparagraph shall result in a reduction of the current rate in accordance with subdivision (c) of section 86-2.2 of this Subpart.] For facilities which have received approval by the commissioner pursuant to Part 710 of this Title to provide services to a patient whose medical condition is HIV Infection Symptomatic, and the facility is not eligible for separate and distinct payment rates pursuant to paragraph (2) of this subdivision, the patient classification group case mix index for AIDS patients which is used to establish direct cost reimbursement shall be increased by an increment of 1.0.

TN 91-25 Approval Date JUL 11 1991

Supersedes TN 90-10 Effective Date APR 1 - 1991

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(q) Long term ventilator dependent residents. [Adjustments to the operating portion of rates for facilities] Facilities which have been approved to operate discrete units for the care of long-term ventilator dependent residents [as established pursuant to section 416.13 of this Title] shall [be made] have separate and distinct payment rates for such units calculated pursuant to this section except as follows:

(1) The facility specific direct adjusted price per day shall be determined as follows:

[(1)](a) In determining the facility specific direct adjusted payment price per day pursuant to paragraph (4) of subdivision (c) of this section for [patients] residents meeting the criteria [established in section 416.13 of this Title] and residing in a discrete unit for the care of long-term ventilator dependent [patients] residents, [separate and distinct statewide mean, base, and ceiling prices shall be calculated and applied by multiplying the case mix proxy for such patients established by this subdivision times the statewide mean, base, and ceiling direct case mix neutral cost per day respectively.] the case mix index used to establish the statewide ceiling direct price per day for each patient classification group pursuant to subparagraph (iii) of paragraph (3) of subdivision (c) of this section for such residents shall be increased by an increment of 1.15. In determining the case mix adjustment pursuant to paragraph (6) of subdivision (c) of this section, the case mix index used to calculate the facility specific mean price for each patient classification group shall be increased by an increment of 1.15.

(b) The increments established in subparagraph (a) of paragraph (1) of this subdivision shall be audited and such increment shall be retrospectively or prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facility's cost report submitted pursuant to this Subpart is less than the staffing pattern required by the Department to operate a ventilator-dependent unit. A current period audit of current expenses may result in a negative adjustment to the increment on a prospective basis. An audit of prior period expenses may result in a retrospective negative adjustment to this increment.

(c) The allowable costs for the central service supply functional cost center as listed in paragraph (1) of subdivision (c) of this section shall be considered a noncomparable cost reimbursed pursuant to subdivision (f) of this section.

(d) The allowable costs for prescription drugs, specifically required by generally accepted standards of professional practice for long-term ventilator dependent residents, that are administered at a frequency and volume exceeding those of prescription drugs included in the direct component of the rate pursuant to subdivision (c) of this section shall be considered a noncomparable cost pursuant to subdivision (f) of this section.

[(2) For purposes of this subdivision, the case mix proxy solely for patients residing in a discrete unit for the care of long term ventilator dependent patients shall be defined as a case mix index of 2.52.]

(2) In determining the indirect component of a facility's rate pursuant to paragraphs (4), (5), and (6) of subdivision (d) of this section for residents meeting the criteria.

and residing in a discrete unit for the care of long-term ventilator dependent residents, a facility's indirect costs shall be compared to the per group established pursuant to clause (d)(2)(iii)(a) of this section.

(3) The noncomparable component of such facilities' rates shall be determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this ~~[part]~~ Subpart including approved actual costs in such cost report for personnel ~~required by~~ identified in ~~section 415.38 of this title~~ Appendix 2 of this State Plan that would be reported in the functional cost centers identified in subdivision (f) of this section.

~~[(4) The provisions of this subdivision will expire on December 31, 1994.~~

TN 95-04 Date JUN 4 - 1999
Supersedes TN 93-04 Date JAN - 1 1995

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(r) Nursing salary adjustment. (1) The adjustment to the operating portion of the rate to reflect the costs of retaining and recruiting nursing services shall be made as follows:

(i) A percentage figure shall be determined as follows:

(a) An average annual statewide increase in registered nurses and licensed practical nurses salaries between the calendar year ending 1987 and calendar year ending 1988 shall be determined based on the available ratified nursing contracts for general hospital services and an average annual regional increase in registered nurses and licensed practical nurses salaries between the calendar year ending 1987 and calendar year ending 1988 shall be determined based upon availalbe information for residential health care facilities.

(b) The average annual regional and statewide increase in salaries shall be multiplied by the total number of nursing staff in the region and the total number of nursing staff statewide respectively to arrive at the total regional and statewide adjustment to be made to facilities. The total regional adjustments shall be determined using the regions contained in Appendix 13-A herein.

(c) The adjusted base shall be determined by multiplying the facility specific mean price per day determined pursuant to subparagraph (i) of paragraph (4) of subdivision (c) of this section by total patient days for each facility and the result shall be summed on a regional and statewide basis.

(d) The total adjustment to be made for all facilities determined pursuant to clause (b) of this subparagraph shall be divided by the adjusted base determined pursuant to clause (c) of this subparagraph on a regional and statewide basis to determine the regional percentage increase and the statewide percentage increase.

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